

**IN THE UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF PENNSYLVANIA**

MICHAEL McKINNIS	:	CIVIL ACTION
	:	
vs.	:	
	:	
HARTFORD LIFE AND ACCIDENT	:	
INSURANCE COMPANY (Incorrectly	:	
styled as Hartford Life)	:	NO. 02-cv-3512

---

**APPENDIX TO DEFENDANT'S MOTION FOR SUMMARY JUDGMENT**

---

H-1 through H-48	Hartford Life and Accident Insurance Company Policy
H-49 through H-110	Administrative Record



Hartford Life

June 7, 2001

Michelle Clingan  
Worldcom, Inc.  
707 17th Street  
Denver, CO 80202

Policy Holder: Worldcom, Inc.  
Claimant: Michael Mckinnis  
SSN: 486-78-0946  
Policy Number: GRH 673565

Dear Ms. Clingan:

We are writing to you regarding the claim for Short Term Disability (STD) benefits on behalf of Michael Mckinnis.

We have completed our review of this claim and have determined that Mr. Mckinnis was not an active full time employee at the time of disability.

Therefore, we have denied this claim for benefits and have notified Mr. Mckinnis of our decision.

If you have any questions, please feel free to contact our office at (800) 729-1783. Our office hours are 8:00 AM to 6:00 PM EST, Monday through Friday.

Sincerely,

Tina M. Palmer, Examiner  
Hartford Life and Accident Insurance Co.

Benefit Management Services  
Syracuse Disability Claim Office  
P.O. Box 4726  
Syracuse, NY 13221-8922  
Fax (315) 474-3849



Hartford Life

June 7, 2001

Michael Mckinnis  
2000 Hamilton St # A569  
Philadelphia, PA 19130

Policy Holder: Worldcom, Inc.  
Claimant: Michael Mckinnis  
SSN: 486-78-0946  
Policy Number: GRH 673565

Dear Mr. Mckinnis:

We are writing to you regarding your claim for Short Term Disability (STD) benefits under the group policy number GRH 673565 for Worldcom, Inc.. This policy funds Worldcom, Inc. STD Employee Benefits Plan. We have completed our review of your claim for benefits and have determined that the evidence submitted in support of your claim does not establish that you meet the definition of eligibility. Accordingly, STD benefits are not payable to you.

Benefits are payable under the policy if Total Disability or Totally disabled means that you are prevented by:

- 1) Accidental bodily injury;
- 2) Sickness;
- 3) Mental Illness;
- 4) Substance abuse; or
- 5) Pregnancy,

From performing the essential duties of your occupation, and as a result, you are earning less than 20% of your pre-disability Weekly Earnings.

Exclusions of benefits per the MCI Worldcom policy language on page 10, under What Disabilities are not covered?

- (1) Injury, sickness, Mental Illness, Substance Abuse, or pregnancy not being treated by a Physician or surgeon;
- (2) Disability caused or contributed to by war or act of war (declared or not);
- (3) Disability caused by your commission of or attempt to commit a felony, or to which a contributing cause was your being engaged in an illegal occupation;
- (4) Disability caused or contributed to by an intentionally self-inflicted injury;
- (5) Sickness or injury for which workers' compensation benefits are paid, or may be paid, if duly claimed; or

Benefit Management Services  
Syracuse Disability Claim Office  
P.O. Box 4726  
Syracuse, NY 13221-8922  
Fax (315) 474-3849

H-50

(6) Injury sustained as a result of doing any work for pay or profit for another employer.

If you are receiving, or are eligible to receive, benefits for a disability under a prior plan of disability benefits that:

- (1) was sponsored by the Employer; and
- (2) was terminated on the day before the effective date of this plan,

then no benefits will be payable for the disability under this Plan.

We based our decision to deny your claim for benefits on policy language and all of the documents contained in your claim file, viewed as a whole, including the following specific information:

Termination define for the policy language of MCI Worldcom's plan booklet on page 11:

When does your coverage terminate?

Your coverage will terminate on the earliest of:

- (1) the date this Group Insurance terminates;
- (2) the date this Group Insurance no longer provides coverage for your class;
- (3) the date premium payment is due but not paid by the employer;
- (4) the last day of the period for which you make any required premium contribution, if you fail to make any further required contribution;
- (5) the date on which you cease to be an Active Full-time Employee in an eligible class, including:
  - (a) temporary layoff;
  - (b) leave of absence, including but not limited to leave for military service;
  - (c) work stoppage (including a strike or lockout); or
  - (d) the date your Employer ceases to be a Participant Employer, if applicable.

\*On 4/23/01, you called and initiated your Short Term Disability claim.

\*On 5/5/01, we received from your employer eligibility certification information.

\*On 5/18/01, Suzanne from Dr. Petrone's office called in medical information for your Short Term Disability claim.

\*On 6/6/01, Contacted Dr. Petrone's office and spoke to Joy for additional medical information.

\*On 6/6/01, Contacted Dr. Pribitkin's office and spoke to Rachel for additional medical information.

\*On 6/7/01, we contacted your employer's human resource Dorrine Blea for further verification on coverage.

On 5/18/01, Suzanne from Dr. Petrone called our office to submit medical information on your claim. Dr. Petrone disabled you on 5/18/01.

On 6/6/01, we contacted Dr. Petrone's office and spoke to Joy. She indicated that you started seeing the physician for the first time as of 5/18/01. Dr. Petrone would not certify any disability prior to this date. Joy indicated your prior physician was Dr. Pribitkin.

On 6/6/01, we contacted Dr. Pribitkin's office spoke to Rachel. She indicated you were only seen on 5/2/01.

On 6/7/01, we contacted Dorrine Blea with your company. She indicated that there has been no family medical leave form received. You have sick time paid through 4/27/01 and no vacation time.

Based upon our review of the plan language and the information provided by Dorrine Blea from the human resource department. The medical information provides Dr. Petrone indicated he will not certify disability prior to your first office visit of 5/18/01. We reviewed your claim; the Hartford Life considered your claim file as a whole for purposes to determine your entitlement to plan benefits. With no indication that you were treated by a physician or medical certification for your disability from your last day work of 4/20/01 through 5/17/01. The date on which you cease to be an active full time employee in an eligible class, including: leave of absence supports your non-eligibility for Short Term Disability benefits.

If you have any additional information, not previously submitted, which you believe will assist us in evaluating your claim for STD benefits, please forward that information to us within sixty (60) days from the date of this letter. In particular, specific functional limitations, restrictions, any diagnostic, x-ray, MRI and cat scan results. All medical documentation from all treating physicians including physical therapy notes if applies to your condition that supports your disability that is preventing you from performing the essential duties of your occupation may assist us in further evaluating your claim for benefits. The Hartford will review any additional information you submit, along with previously submitted information, and will notify you of the results of our review.

If you do not have additional information, but you disagree with our denial decision, the Employee Retirement Income Security Act of 1974 (ERISA) provides you with the right to appeal our decision and review pertinent documents in your claim file. If you do not agree with the reason why your claim was denied, in whole or in part, and you wish to appeal our decision, you must write to us within sixty (60) days of the date of this letter. Your letter, which must be signed and dated by you or your legal representative, should clearly outline your position and any issues or comments you have in connection with your claim and our decision to deny your request for benefits under the Policy. Once we receive your appeal, your claim will be reviewed based upon your statements and the documents and notes contained in your claim file. Upon completion of that review, we will advise you of our further determination.

If you have any questions, please feel free to contact our office at (800) 729-1783. Our office hours are 8:00 AM to 6:00 PM EST, Monday through Friday.

Sincerely,

Tina M. Palmer, Examiner  
Hartford Life and Accident Insurance Co.



Hartford Life

May 26, 2001

Michael Mckinnis  
2000 Hamilton St # A569  
Philadelphia, PA 19130

Policy Holder: Worldcom, Inc.  
Claimant: Michael Mckinnis  
SSN: 486-78-0946  
Policy Number: GRH 673565

Dear Mr. Mckinnis:

In order to fully evaluate this claim for Short Term Disability (STD) benefits, we need the following information:

Based on the information we received, your effective date of coverage under this policy was 08/01/2000. Since your disability began within the first 90 days of your coverage, we must investigate your claim to be sure that your disability has not resulted from a pre-existing condition.

Please have your physician(s) send in all medical records and test results between the look back period of 10/3/00 through 12/31/00 for your present condition. Also, will need Dr. Silver's dictation notes on his evaluation of your first office visit. Your employer needs to send in sick hours paid to you from 4/20/01 through 5/17/01 or medical information that certifies your disability during this period with complications, restrictions, functional limitations, treatment plan and estimated return to work date. All information is due on or prior to 6/11/01.

Please return all requested information within thirty (30) days in order to avoid any delays in processing your claim for benefits.

If you have any questions, please feel free to contact our office at (800) 729-1783. Our office hours are 8:00 AM to 6:00 PM EST, Monday through Friday.

Sincerely,

Tina M. Palmer, Examiner  
Hartford Life and Accident Insurance Co.

Benefit Management Services  
Syracuse Disability Claim Office  
P.O. Box 4726  
Syracuse, NY 13221-8922  
Fax (315) 474-3849



Hartford Life

May 17, 2001

Michael Mckinnis  
2000 Hamilton St # A569  
Philadelphia, PA 19130

Policy Holder: Worldcom, Inc.  
Claimant: Michael Mckinnis  
SSN: 486-78-0946  
Policy Number: GRH 673565

Dear Mr. Mckinnis:

We are writing to you regarding your claim for Short Term Disability (STD) benefits under the group policy number GRH 673565 for Worldcom, Inc.. Benefits are payable under this policy if "as a result of an Illness or Injury, you:

1. become Totally Disabled while you are eligible under this policy;
2. require the regular care of a Physician; and
3. submit proof of your Total Disability".

We have not received the provider information. This information was requested on 04/23/2001 and 05/02/2001. As it is required, we are unable to completely evaluate your claim for benefits and have closed your file.

If you can provide the provider information indicated above, or any additional information not previously submitted, which you believe will assist us in evaluating your claim for STD benefits, please forward it to us within sixty (60) days from the date of this letter. Hartford Life will review any additional information submitted and will notify you of the results of our review.

If you do not have additional information, but you disagree with our decision, the Employee Retirement Income Security Act of 1974 (ERISA) provides you with the right to appeal our decision and review pertinent documents in your claim file. If you do not agree with the reason why your claim was closed, in whole or in part, and you wish to appeal our decision, you must write to us within sixty (60) days of the date of this letter. Your letter, which must be signed and dated by you or your legal representative, should clearly outline your position and any issues or comments you have in connection with your claim and our decision. Once we receive your appeal, your claim will be reviewed based upon your statements and the documents and notes contained in your claim file. Upon completion of that review, we will advise you of our further determination.

Benefit Management Services  
Syracuse Disability Claim Office  
P.O. Box 4726  
Syracuse, NY 13221-8922  
Fax (315) 474-3849

H-55



If you have any questions, please feel free to contact our office at (800) 729-1783. Our office hours are 8:00 AM to 6:00 PM EST, Monday through Friday.

Sincerely,

Stacey L. Juston, Examiner  
Hartford Life and Accident Insurance Co.



Hartford Life

April 23, 2001

Michael Mckinnis  
2000 Hamilton St # A569  
Philadelphia, PA 19130

Policy Holder: Worldcom, Inc.  
Claimant: Michael Mckinnis  
SSN: 486-78-0946  
Policy Number: GRH 673565

Dear Mr. Mckinnis:

**IMPORTANT INFORMATION REGARDING YOUR SHORT TERM DISABILITY BENEFITS  
PLEASE READ THIS LETTER CAREFULLY**

Thank you for your recent call providing notice of your Short Term Disability Claim. As discussed in our telephone conversation, this letter reiterates the information required to evaluate your claim. Please find a list of necessary information below:

1. Confirmation of Coverage from your employer. We have requested this information.
2. Information from your physician's office regarding your functional capabilities and limitations. As discussed, your physician's office must call Hartford Life, Inc. at (800) 729-1783 as soon as possible. If you have not contacted your physician's office, please do so immediately to request that they call us. Please ask that they have your chart available to provide the following information as applicable:
  - Diagnosis and procedures performed
  - Treatment dates, treatment plan and medications
  - Examination findings and diagnostic test results
  - Specific limitations affecting your ability to work
  - Expected recovery dates and treatment plan

After we have received your employer and physician information, your claim will be evaluated and we will determine if you are eligible to receive benefits.

Benefit Management Services  
Syracuse Disability Claim Office  
P.O. Box 4726  
Syracuse, NY 13221-8922  
Fax (315) 474-3849

If you have any questions, please feel free to contact our office at (800) 729-1783. Our office hours are 8:00 AM to 6:00 PM EST, Monday through Friday.

Sincerely,

Mona I. Malfa, Senior Examiner  
Hartford Life and Accident Insurance Co.

facsimile  
TRANSMITTAL  
[REDACTED]

**LAW OFFICE OF ADRIAN R. REID, P.C.**

**2207 CHESTNUT STREET - PHILADELPHIA, PA 19103 (267) 256-0901**

**Name:** Tina Palmer  
**Organization:** Hartford Life Philadelphia Housing Authority  
**Fax:** (315) 474-3849  
**Phone:** (800) 729-1783  
**From:** ADRIAN R. REID, ESQ.  
**Date:** October 9, 2001  
**Subject:** Policy Holder: Worldcom, Inc.  
Claimant: Michael McKinnis  
Policy No. 673565  
**cc:**  
**Pages:** 3

2 DW  
4-20-01

\*\*\*\*\*  
**PLEASE NOTE:** The information contained in this facsimile message is privileged and confidential and is intended only for the use of the individual or entity named above and others who have been specifically authorized to receive it. If you are not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, or if any problems occur with transmission, please notify us immediately by telephone. Thank you.

H-59

**Law Office of  
ADRIAN R. REID, ESQUIRE  
2207 Chestnut Street  
Suite 200  
Philadelphia, PA 19103  
Phone 267-256-0901 Fax 267-256-0911**

October 9, 2001

Via Telefax and First Class Mail  
(315) 474-3849

Ms. Tina Palmer  
Hartford Life and Accident Insurance  
P.O. Box 4726  
Syracuse, New York 13221-8922

RE:	Policy Holder: Worldcom, Inc.
Claimant:	Michael McKinnis
S.S.	486-78-0946:
Policy Number:	GRH 673565

Please accept this correspondence as a Letter of Representation on behalf of the above-named individual. Enclosed is a copy of Mr. McKinnis's authorization for release of information to me pertaining to matters of his claim.

Kindly send all future correspondence to my attention. Upon receipt of this letter, please contact me.

Very truly yours,



Adrian R. Reid

ARR:rfi  
Enclosure

H-60

**AUTHORIZATION**

**TO WHOM IT MAY CONCERN:**

This will authorize you to release to my attorneys, RODGERS AND REID, their agent(s) or representative(s) the originals or true and correct copies of any and all hospital, medical, police, employment and earnings, bank or other research records, information, and/or other documentation requested by them in connection with the matters wherein they represent me.

My above-named attorneys have been retained by me to prosecute a claim, and your full cooperation with them is requested. You are further instructed to disclose no information to any person(s) without written authority from us to do so.

This shall constitute their sufficient Power of Attorney for obtaining such information, records, and/or documentation.

  
\_\_\_\_\_

Date: 9/17/01

PHOTOCOPY WILL BE SUFFICIENT

H-61



Dorrine Blea <Dorrine.Blea@wcom.com> on 05/03/2001 04:40:23 PM

To: Hartford <mci.syracuse@hartfordlife.com>  
cc: hr image <hr-image@wcom.com>, Michelle Clingan <michelle.clingan@wcom.com>  
Subject: Michael Mckinnis

SSN: 486-78-0946      NAME: Mckinnis, Michael  
ADDRESS: 2000 Hamilton St # A569  
Philadelphia, PA 19130

DEPARTMENT CODE: >  
REGION CODE: BE>  
LOCATION CODE: 630>

DATE HIRED: 24-JAN-2000>

JOB TITLE: Sr Sales Rep>  
WORK RELATED (Y/N): N>  
LAST DAY WORKED: 20-APR-2001>  
STD COVERAGE EFF DATE: 01-AUG-2000>  
LTD COVERAGE EFF DATE: 01-AUG-2000>  
DISABILITY DATE: 23-APR-2001>  
SICK PAY PAID THROUGH: none>



- winmail.dat

Worldcom  
BGS

*Law Office of*  
**ADRIAN R. REID**  
*2207 Chestnut Street*  
*Suite 200*  
*Philadelphia, PA 19103*  
*Phone 267-256-0901 Fax 267-256-0911*

October 16, 2001

Tina Palmer  
Hartford Life  
P.O. Box 4726  
Syracuse, NY 13221-8922

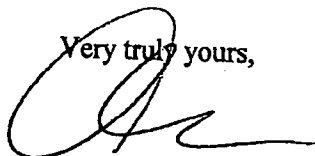
**RE: Policy Holder: Worldcom, Inc.**  
**Claimant: Michael McKinnis**  
**Policy# GRH 673565**

486-78-0946

Dear Ms. Palmer:

Attached please find a Authorization form signed by my client requesting his disability records. Please contact me upon receipt of same.

Very truly yours,



Adrian R. Reid

ARR/at

H-63



October 15, 2001

**AUTHORIZATION**


THE HARTFORD INSURANCE COMPANY:

RE: DISABILITY RECORDS

This will authorize you to release to my attorneys, RODGERS AND REID, their agent(s) or representative(s) the originals or true and correct copies of any and all hospital, medical, police, employment and earnings, bank or other research records, information, and/or other documentation requested by them in connection with the matters wherein they represent me.

My above-named attorneys have been retained by me to prosecute a claim, and your full cooperation with them is requested. You are further instructed to disclose no information to any person(s) without written authority from us to do so.

This shall constitute their sufficient Power of Attorney for obtaining such information, records, and/or documentation.

 \_\_\_\_\_

Date: \_\_\_\_\_

Oct. 15, 2001

PHOTOCOPY WILL BE SUFFICIENT

H-64

*Law Office of*  
**ADRIAN R. REID**  
*2207 Chestnut Street*  
*Suite 200*  
*Philadelphia, PA 19103*  
*256-0901 Fax 267-256-0911*

**Tina Palmer  
Hartford Life  
P.O. Box 4726  
Syracuse, NY 13221-8922**

Dear Ms. Palmer:

Very truly yours,

Adrian R. Reid

ARR/at



Dorrine Blea <Dorrine.Blea@wcom.com> on 06/06/2001 04:03:07 PM

To: Tina.Palmer1@hartfordlife.com  
cc:  
Fax to:  
Subject: FW: michael mckinnis 486 78 0946

LDW  
4-20-01

Tina,

This employee did in fact have sick time and was paid through 4/27, no vacation has been paid out at this time.

Dorrine

-----Original Message-----

From: Tina.Palmer1@hartfordlife.com  
[mailto:Tina.Palmer1@hartfordlife.com]  
Sent: Wednesday, June 06, 2001 1:43 PM  
To: dorrine.blea@wcom.com  
Subject: michael mckinnis 486 78 0946

Did employee use any vacation or sick time during 4/20/01 through 5/18/01....Please let me know.  
Thanks.



Dorrine Blea <Dorrine.Blea@wcom.com> on 06/06/2001 04:08:08 PM

To: Tina.Palmer1@hartfordlife.com  
cc:  
Fax to:  
Subject: FW: michael mckinnis 486 78 0946

He should be, but I haven't received the FMLA form yet. I'm sure you have received as many calls as I have from him. Let me know if you need anything else.

Dorrine

-----Original Message-----

From: Tina.Palmer1@hartfordlife.com  
[mailto:Tina.Palmer1@hartfordlife.com]  
Sent: Wednesday, June 06, 2001 1:53 PM  
To: dorrine.blea@wcom.com  
Subject: michael mckinnis 486 78 0946

sorry - also need to know if ee was on any fmla during this time ?

Thanks for your help.

----- Forwarded by Tina M Palmer/H LIFE on 06/06/2001 03:51 PM -----

Tina M Palmer  
06/06/2001 03:42 PM

To: dorrine.blea@wcom.com  
cc:  
Fax to:  
Subject: michael mckinnis 486 78 0946

Did employee use any vacation or sick time during 4/20/01 through 5/18/01....Please let me know.  
Thanks.

LSDW  
4-20-01Worldcom  
AW

William Silver D.S.W.  
1537 Lombard Street  
Philadelphia, PA 19146

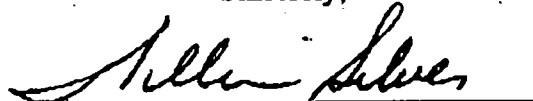
Dx 296.23  
305.00

I saw Michael McKinnis on two occasions, 4/26 and 5/2/01. At the time Michael was experiencing symptoms of depression and anxiety, to the point that he felt he could not work. He felt that there were many personal factors contributing to his anxiety including substance abuse, financial concerns, aging and work related pressures. He notes these symptoms have continued for the past 6 months.

Michael has an alcohol abuse problem, drinking one to two bottles a week. He has also used cocaine, but said he's stopped that at this time. Many areas of Michael's life are in chaos. He has relationship problems as well as career problems. He would ultimately like to change careers for a less stressful job.

It is my recommendation, and Michael concurs, that he would do well in an alcohol rehabilitation program, followed by outpatient treatment. He is impulsive, and the structure of the program would give him the opportunity to focus on some of his life goals. He seems motivated to get hold of his life.

Sincerely,

  
6106644029 PAGE.01

JUN 01 2001 18:31

486780946

Person Medical Care - Fairmount

# Progress Notes

McInnis, Michael  
Complete or Imprint with Address-O-Plate

Problems and Description	Findings (subjective and Objective)	Plans
5/18/01	Wt 227 BP 152/110	
	③ 37 yo ♂ low for African Am: medical heart - ST disch. by for EDDT abuse.	
	Trade: Allergo D Flexerl 10 mg Nasonex (200) -	
	RAS Head - post opypt h/a. - stuck related. Pain 7/10 - sleeps - Takes Valium 10 mg for sleep No nausea. No aura.	
	Ears - popping Nose - (Dressel ingested) Eos Throat - allergic . EDDT CV: No CP - palpitation & stress. No edema - 0 r/t h/p	
	Resp: a dyspnea, cough Asthma previously GI - episodic/stomach burning belching - ↑ to 4th or NUDC or reflux GU: 0 dysuria, 0 ED ↓ ejaculatory center output over past 4 mos.	
	MS: LBP - football in college MVA 1994 - takes Flexerl pm. Ankle pain B/L. Endocrine: "thirsty" all the time - 0 polyuria	

SLR (Rev. 11/98)

MVC 98.504

H-69

MCKINNIS, MICHAEL 6/19/1963

2152329843

PAGE.01

JUN 01 2001 13:15

Date/Problems Location and Description	Findings (subjective and Objective)	Plans
	<p>Psych: Bad sleeping - can't stay asleep. Feeling depressed - job very stressful.</p> <p>Appetite ↓ ↓ orientation.</p> <p>⊕ anhedonia, saying problems getting up in AM.</p> <p>Wants to sleep all the time.</p> <p>⊕ obsessive thinking.</p> <p>Denies suicidality.</p>	<p>1. ...</p> <p>SMALL ...</p> <p>TC ...</p> <p>HRT 25 mg qd</p> <p>Wishes to ref ...</p> <p>⊕ meds with ...</p> <p>be seen ...</p> <p>transport ...</p> <p>next wk</p> <p>Form for ...</p> <p>ST disability</p>
⑩	<p>LA 140/112</p> <p>RA 150/114</p> <p>10-140/98</p> <p>Affect somewhat depressed.</p> <p>Content appropriate.</p> <p>Heard NCAT</p> <p>Neck supple, AP, &amp; MASS, &amp; brach</p> <p>HR 140 &amp; 12, 54</p> <p>Chest CTA</p> <p>Abd soft, NT, &amp; masses</p> <p>Exercises</p> <ul style="list-style-type: none"> <li>• Full ROM</li> <li>• No deformities</li> <li>• pulse 24 b/l.</li> <li>• No edema</li> </ul> <p>Strength 5/5 b/l.</p>	
	<p>⊕ ATN - newly diagnosed</p> <p>Alcohol abuse</p> <p>Depression</p> <p>⊕ Hangerman</p>	
5/31/01	<p>⑤ Disability hasn't kicked in yet -</p> <p>Hartford needs more work.</p> <p>Feeling better.</p>	
⑩	<p>EGT 9 to 155 - other CFT</p> <p>5/6 calculated.</p> <p>BP 160/102</p>	

H-70

MFB

ENC#

Name

McKennis, Michael

 $\therefore RY \approx$ 

**Complete or Imprint with Address-O-Plate**

## Progress Notes

Progress Notes		Plans
Date/Problems No. and Description	Findings (subjective and Objective)	
5/31/01	HA 1102 @ check RTA Pulse at NO response then	FAK 315 474- 1948
		Prinzide 10/12- 10/26
11	HA 1102 RTA none	ERG-
	S. Geyser - LAMP	

**IMPORTANT: DO NOT WRITE IN MARGINS**

[illegible]

H-71



06/01/2001 23:02

Hospital

THOMAS JEFFERSON UNIVERSITY HOSPITAL  
CLINICAL and ANATOMIC PATHOLOGY  
DIRECTOR, FRED GORSTEIN, M.D.

004

LANGNER CRNP (FAIRMOUNT)  
LOUIS PETRONE MD  
FAIRMOUNT AVE  
PA 19130-2515

PATIENT MCKINNIS, MICHAEL  
PATIENT TELEPHONE No. (215) 999-9999  
AGE 37Y SEX M DOB: 06/19/1963  
MR No. 3138771 ACCT No. 21914538

\*\*\*\*\* URINALYSIS: MACROSCOPIC \*\*\*\*\*

DATE:	05/18/01	
TIME:	1200	REF RANGE UNITS
LOC:	NONL	
Color	LIGHT AMBER*	YEL
Appearance	CLEAR	CLER
Spec. Grav.	1.027H	1.010-1.025
pH	5	5-8
Protein	NEG	NEG
Glycose	NEG	NEG
Ketone	NEG	NEG
Bilirubin	NEG	NEG
Blood	NEG	NEG
Nitrite	NEG	NEG
Urobil.	NORMAL	NORM
Leuk. Est.	NEG	NEG

\*\*\*\*\* URINALYSIS: MICROSCOPIC \*\*\*\*\*

DATE:	05/18/01	
TIME:	1200	REF RANGE UNITS
LOC:	NONL	
Cells	NONE SEEN	/HPF
Casts	NONE SEEN	/LPF
Crystals	NONE SEEN	/HPF
Other Observ.	1+ BACTERIA	/HPF

*Handwritten signature*

CONTINUED

FINAL EPISODE REPORT

PAGE 1

PATIENT: MCKINNIS, MICHAEL  
X=NEW DATA THIS REPORT

LOCATION: NONL  
H, L, OR \*=ABNORMAL RESULT PRINTED 05/21/2001 00:17

H-72

THOMAS JEFFERSON UNIVERSITY HOSPITAL  
CLINICAL and ANATOMIC PATHOLOGY  
DIRECTOR, FRED GORSTEIN, M.D.

LANGNER CRNP (FAIRMOUNT)  
LOUIS PETRONE MD  
FAIRMOUNT AVE  
LA PA 19130-2515

PATIENT MCKINNIS, MICHAEL  
PATIENT TELEPHONE No. (215) 999-9999  
AGE 37Y SEX M DOB: 06/19/1963  
MR No. 3138771 ACCT No. 21914538

\*\*\*\*\* BASIC METABOLIC PANEL/CHEM 7 PANEL \*\*\*\*\*

DATE	TIME	LOC	REF RANGE	UNITS
05/18/01	1200	NONL		
Sodium	137		135-146	mmol/L
Potassium	4.2		3.5-5.0	mmol/L
Chloride	104		98-109	mmol/L
CO2	23 L		24-32	mmol/L
Calcium	10		4-16	mmol/L
Glucose	9 L		10-22	mg/dL
BUN	95		60-110	mg/dL
Creatinine	1.1		0.7-1.4	mg/dL
Urea Nitrogen	9.5		8.5-10.5	mg/dL

\*\*\*\*\* HEPATIC PANEL \*\*\*\*\*

DATE	TIME	LOC	REF RANGE	UNITS
05/18/01	1200	NONL		
Albumin	7.5		6.0-8.5	g/dL
Alkaline Phosphatase	4.7		3.2-4.9	g/dL
Aspartate Aminotransferase	0.3		0.2-1.2	mg/dL
Alanine Aminotransferase	0.0		0.0-0.4	mg/dL
Bilirubin	61		29-92	IU/L
AST (GPT)	43 H		7-42	IU/L
ALT (GPT)	46 H		1-45	IU/L

CONTINUED

FINAL EPISODE REPORT

PAGE 2

PATIENT: MCKINNIS, MICHAEL  
DATA THIS REPORT

LOCATION: NONL  
H, L, OR \*-ABNORMAL RESULT PRINTED 05/21/2001 00:17

H-73

Thomas Jefferson University Hospital  
Jefferson Health System

THOMAS JEFFERSON UNIVERSITY HOSPITAL  
CLINICAL and ANATOMIC PATHOLOGY  
DIRECTOR, FRED GORSTEIN, M.D.

SUZANNE LANGNER CRNP (FAIRMOUNT)  
C/O LOUIS PETRONE MD  
2305 FAIRMOUNT AVE  
PHILA PA 19130-2515

PATIENT MCKINNIS, MICHAEL  
PATIENT TELEPHONE No. (215) 999-9999  
AGE 37Y SEX M DOB: 06/19/1963  
MR No. 3138771 ACCT No. 21914538

\*\*\*\*\* SERUM CHEMISTRY \*\*\*\*\*

TEST: GGT  
UNITS: IU/L  
RANGE: 10-40

05/18/01  
1200 155H

*pull chart*

*gc*

\*\*\*\*\* SERUM LIPIDS \*\*\*\*\*

TEST:	Cholesterol	HDL	LDL - (Calc)	Triglyceride
Desirable :	<200 mg/dL	>50mg/dL	<130mg/dL	
Borderline:	200-240mg/dL	40-50mg/dL	130-160mg/dL	
High Risk :	>240 mg/dL	<40mg/dL	>160mg/dL	
UNITS:	mg/dL	mg/dL	mg/dL	mg/dL
RANGE:				50-250

05/18/01				
1200	173	46	102	126

END OF REPORT

FINAL EPISODE REPORT

PAGE 3

PATIENT: MCKINNIS, MICHAEL  
X=NEW DATA THIS REPORT

LOCATION: NONL  
H, L, OR \*=ABNORMAL RESULT PRINTED 05/21/2001 00:17

H-74

*Law Offices of*  
**ADRIAN R. REID**  
**2207 Chestnut Street**  
**Suite 200**  
**Philadelphia, PA 19103**  
**267-256-0901**

Worldcom  
Bcs

TMF

LDW  
4-20-01

VIA: Fax 315-474-3849

The Hartford  
Tina M. Palmer  
P.O. Box 4726  
Syracuse, NY 13221-8922

**RE: Michael McKinnis**  
**Worldcom, Inc.**  
**SSN: 486-78-0946**  
**Policy# GRH 673565**

Dear Ms. Palmer:

Please be advised that I have been retained in the above. Enclosed please find a June 15, 2001 report from Dr. Petrone. It is self-explanatory.

In particular, my client is making a claim for short term disability starting on May 18, 2001. The plain language of the policy as well as your correspondence indicates that he is entitled to same. If you have any questions or concerns please do not hesitate to contact me.

Please be advised that for the purposes of your organization this is a "appeal", as I understand that term to be used by The Hartford.

Very truly yours,

  
Adrian R. Reid

ARR/at

H-75

IMP

Date/Problems or o. and Description	Findings (Subjective and Objective)	Plans
	<p>Psych: Bad sleeping - can't stay asleep. Feeling depressed - job very stressful.</p> <p>Appetite ↓ ↓ concentration.</p> <p>⊕ anhedonia, crying problems getting up in Am.</p> <p>Wants to sleep all the time.</p> <p>⊕ obsessive thinking</p> <p>Rather suicidal</p>	<p>1</p> <p>SMAT, UA EC, CFTs</p> <p>HCTZ 25 mg qd</p> <p>Wishes to refer if needs what he says thru MIT must ask.</p> <p>Form for ST drinking</p>
<p>① LA 140/112 RA 150/114 5/14/98 Affect somewhat depressed. Content appropriate. Heard NCAT Nose supple, NT, &amp; masses, &amp; brach RT arm, &amp; 5/54 Chest DTA Rhd sple, NT, &amp; masses Exercises</p> <ul style="list-style-type: none"> <li>• Fall Norm</li> <li>• No deformities</li> <li>• pulses 2+ b/l.</li> <li>• No edema</li> </ul> <p>Strength 5+ b/l.</p>		
	<p>⊕ ATN - newly diagnosed PTSD 1 NK Alcohol abuse Depression</p> <p style="text-align: right;">S. Hargreaves</p>	
5/31/01	<p>⑤ Disability hasn't kicked in yet - Hartford needs more money. Feeling better.</p>	
①	<p>GGT ↑ to 155 - other LFTs SLi calculated. BP 140/102</p>	

MAJ 525090

H-76

NORMAN BROUDY, M.D.  
& ASSOCIATES

WILLIAM SILVER, DSW



Hartford Life

TELEPHONE  
(302) 655-7110 EXT. 29

825 WASHINGTON STREET  
WILMINGTON, DELAWARE 19801

Michael McKinnis  
2000 Hamilton St # A569  
Philadelphia, PA 19130

Policy Holder: Worldcom, Inc.  
Claimant: Michael McKinnis  
SSN: 486-78-0946  
Policy Number: GRH 673565

Dear Mr. McKinnis:

**IMPORTANT INFORMATION REGARDING YOUR SHORT TERM DISABILITY BENEFITS  
PLEASE READ THIS LETTER CAREFULLY**

Thank you for your recent call providing notice of your Short Term Disability Claim. As discussed in our telephone conversation, this letter reiterates the information required to evaluate your claim. Please find a list of necessary information below:

1. Confirmation of Coverage from your employer. We have requested this information.
2. Information from your physician's office regarding your functional capabilities and limitations. *Please Call this number to Give Info.*  
As discussed, your physician's office must call Hartford Life, Inc. at (800) 729-1783 as soon as possible. If you have not contacted your physician's office, please do so immediately to request that they call us. Please ask that they have your chart available to provide the following information as applicable:
  - Diagnosis and procedures performed
  - Treatment dates, treatment plan and medications
  - Examination findings and diagnostic test results
  - Specific limitations affecting your ability to work
  - Expected recovery dates and treatment plan

*Any Q. Call me at this number.*

*215-266-4646  
Mike*

After we have received your employer and physician information, your claim will be evaluated and we will determine if you are eligible to receive benefits.

*5/18/01  
Hartford notified  
JL*

Benefit Management Services  
Syracuse Disability Claim Office  
P.O. Box 4726  
Syracuse, NY 13221-8922  
Fax (315) 474-3849

H-77



Thomas Jefferson University Hospital  
Jefferson Health System

MR#

ENC#

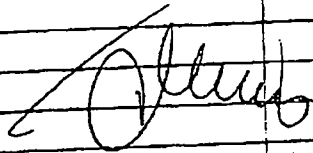
Name

Mickens, Michael

Jefferson Medical Care - Fairmount  
Progress Notes

## Progress Notes

**Complete or Imprint with Address-O-Plate**

Progress Notes		Plans
Date/Problems No. and Description	Findings (subjective and Objective)	
5/30/01	HA-MAN + @ check CTA Pulse 24 NO peripheral clots	FAQ 315 474- 1948
		Prinzide 10/12-5 10/26
11	HA-MAN ETOH abuse	ERG-
	15 Glycerol IRASP	RTD 2 Wks ✓ BP
		

**IMPORTANT: DO NOT WRITE IN MARGINS**





Thomas Jefferson University Hospital  
 Jefferson Health System

MR#  
 ENC#  
 Name

Michael McKinnis

Jefferson Medical Care - Fairmount  
 Progress Notes

Complete or Imprint with Address-O-Plate

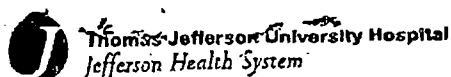
Date/Problems No. and Description	Findings (subjective and Objective)	Plans
5/18/01	Wt 221 BP 152/110	
③	37 yd ♂ low for Mom as: medical heart - ST disability for EDDT abuse.	
	Med: Nitroglycerin D Nasomup Flexon (10 mg) (200) -	
	<u>RAS</u> Head - post opus h/a. - stress related. Pain 7/10 - sleep - Taken Valium 10 mg for sleep No nausea. No auras.	
	Ears - popping Nose - (P) nasal congestion } Sin Throat - allergic } 600 CV: No CP - palpitation & stress. No edema - 8 other pm.	
	Resp. a dyspnea, cough - Asthma prophylaxis; GI - epigastric/stomach burning h/ing. - ↑ to 200 & NUDC & nausea GU: & dysuria, & ED ↓ ejaculating semen output over past 4 mos. MS: LBP - football on collar MVA 1994 - takes Flexon pm. Ankle pain bil. Endocrine - "thirsty" all the time & polyuria	

IMPORTANT: DO NOT WRITE IN MARGINS

Form 60505-001 (Rev. 11/97)

H-79





THOMAS JEFFERSON UNIVERSITY HOSPITAL  
CLINICAL and ANATOMIC PATHOLOGY  
DIRECTOR, FRED GORSTEIN, M.D.

SUZANNE LANGNER CRNP (FAIRMOUNT)  
C/O LOUIS PETRONE MD  
2305 FAIRMOUNT AVE  
PHILA PA 19130-2515

PATIENT MCKINNIS, MICHAEL  
PATIENT TELEPHONE No. (215) 999-9999  
AGE 37Y SEX M DOB: 06/19/1963  
MR No. 3138771 ACCT No. 21914538

\*\*\*\*\* BASIC METABOLIC PANEL/CHEM 7 PANEL \*\*\*\*\*

DATE:	05/18/01	REF RANGE	UNITS
TIME:	1200		
LOC:	NONL		
Sodium	137	135-146	mmol/L
Potassium	4.2	3.5-5.0	mmol/L
Chloride	104	98-109	mmol/L
CO2	23 L	24-32	mmol/L
Anion Gap	10	4-16	mmol/L
Urea-N	9 L	10-22	mg/dL
Glucose	95	60-110	mg/dL
Creatinine	1.1	0.7-1.4	mg/dL
Calcium	9.5	8.5-10.5	mg/dL

\*\*\*\*\* HEPATIC PANEL \*\*\*\*\*

DATE:	05/18/01	REF RANGE	UNITS
TIME:	1200		
LOC:	NONL		
Total Protein	7.5	6.0-8.5	g/dL
Albumin	4.7	3.2-4.9	g/dL
Total Bili	0.3	0.2-1.2	mg/dL
Direct Bili	0.0	0.0-0.4	mg/dL
Alk Phos	61	29-92	IU/L
AST (GOT)	43 H	7-42	IU/L
ALT (GPT)	46 H	1-45	IU/L

CONTINUED

FINAL EPISODE REPORT

PAGE 2

PATIENT: MCKINNIS, MICHAEL  
X=NEW DATA THIS REPORT

LOCATION: NONL  
H. L. OR \*=ABNORMAL RESULT PRINTED 05/21/2001 00:17

H-80



Thomas Jefferson University Hospital  
 Jefferson Health System

THOMAS JEFFERSON UNIVERSITY HOSPITAL  
 CLINICAL and ANATOMIC PATHOLOGY  
 DIRECTOR, FRED GORSTEIN, M.D.

SUZANNE LANGNER CRNP (FAIRMOUNT)  
 C/O LOUIS PETRONE MD  
 2305 FAIRMOUNT AVE  
 PHILA PA 19130-2515

PATIENT MCKINNIS, MICHAEL  
 PATIENT TELEPHONE No. (215) 999-9999  
 AGE 37Y SEX M DOB: 06/19/1963  
 MR No. 3138771 ACCT No. 21914538

\*\*\*\*\* URINALYSIS: MACROSCOPIC \*\*\*\*\*

DATE:	05/18/01	REF RANGE	UNITS
TIME:	1200		
LOC:	NONL		
Color	LIGHT AMBER*		YEL
Appearance	CLEAR		CLER
Spec. Grav.	1.027H	1.010-1.025	
pH	5		5-8
Protein	NEG		NEG
Glucose	NEG		NEG
Ketone	NEG		NEG
Bilirubin	NEG		NEG
Blood	NEG		NEG
Nitrite	NEG		NEG
Urobil.	NORMAL		NORM
Leuk. Est.	NEG		NEG

\*\*\*\*\* URINALYSIS: MICROSCOPIC \*\*\*\*\*

DATE:	05/18/01	REF RANGE	UNITS
TIME:	1200		
LOC:	NONL		
Cells	NONE SEEN		/HPF
Casts	NONE SEEN		/LPF
Crystals	NONE SEEN		/HPF
Other Observ.	1+ BACTERIA		/HPF

*Handwritten signature*

CONTINUED

FINAL EPISODE REPORT

PAGE 1

PATIENT: MCKINNIS, MICHAEL  
 x=NEW DATA THIS REPORT

LOCATION: NONL  
 H, L, OR \*=ABNORMAL RESULT PRINTED 05/21/2001 00:17

H-81



Thomas Jefferson University Hospital  
Jefferson Health System

THOMAS JEFFERSON UNIVERSITY HOSPITAL  
CLINICAL and ANATOMIC PATHOLOGY  
DIRECTOR, FRED GORSTEIN, M.D.

SUZANNE LANGNER CRNP (FAIRMOUNT)  
C/O LOUIS PETRONE MD  
2305 FAIRMOUNT AVE  
PHILA PA 19130-2515

PATIENT MCKINNIS, MICHAEL  
PATIENT TELEPHONE No. (215) 999-9999  
AGE 37Y SEX M DOB: 05/19/1963  
MR No. 3138771 ACCT No. 21914538

\*\*\*\*\* SERUM CHEMISTRY \*\*\*\*\*

TEST: GGT  
UNITS: IU/L  
RANGE: 10-40

05/18/01  
1200 155H

*pull down*

*[Signature]*

\*\*\*\*\* SERUM LIPIDS \*\*\*\*\*

TEST:	Cholesterol	HDL	LDL-(Calc)	Triglyceride
Desirable :	<200 mg/dL	>50mg/dL	<130mg/dL	
Borderline:	200-240mg/dL	40-50mg/dL	130-160mg/dL	
High Risk :	>240 mg/dL	<40mg/dL	>160mg/dL	
UNITS:	mg/dL	mg/dL	mg/dL	mg/dL
RANGE:				60-250

05/18/01				
1200	173	46	102	126

END OF REPORT

FINAL EPISODE REPORT

PAGE 3

PATIENT: MCKINNIS, MICHAEL  
x=NEW DATA THIS REPORT

LOCATION: NONL  
H, L, OR \*=ABNORMAL RESULT PRINTED 05/21/2001 00:17

H-82

05/31/2001 10:35:11 AM MCKINNIS, MICHAEL  
38 years Male

BP: Jefferson Medical Care

Oper: MPH

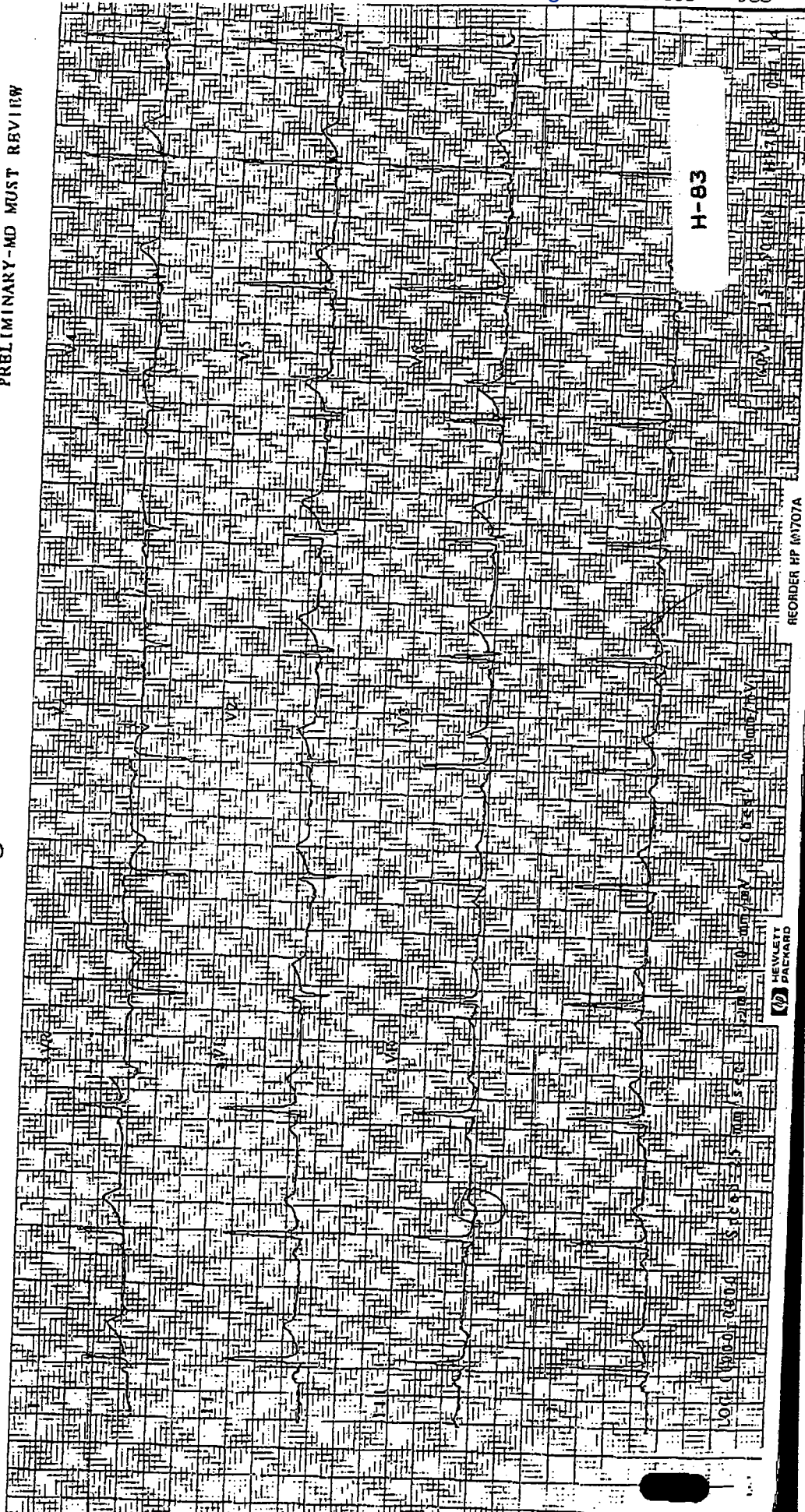
Rate 70 Normal sinus rhythm rate 70  
PR 151 Early transition  
QRS 77 Nonspecific inferior T abnormalities  
QT 330  
QTc 366  
T neg or T/ORS ratio <.05 2,3,4

--AXIS--  
P 67  
QRS 65  
T 15

Requested by:  
LANGNER

BORDERLINE UCG -

PRELIMINARY-MD MUST REVIEW



HEWLETT  
PACKARD

REORDER HP M707A

##### 5. Permanent/Long-term Conditions Requiring Supervision

A period of incapacity<sup>2</sup> which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

##### 6. Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity<sup>1</sup> of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

H-84



A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. Hospital Care

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity<sup>2</sup> or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

(a) A period of incapacity<sup>2</sup> of more than three consecutive calendar days (including any subsequent treatment or period of incapacity<sup>2</sup> relating to the same condition), that also involves:

(1) Treatment<sup>3</sup> two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or

(2) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment<sup>4</sup> under the supervision of the health care provider.

3. Pregnancy

Any period of incapacity due to pregnancy, or for prenatal care.

4. Chronic Conditions Requiring Treatments

A chronic condition which:

(1) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

(2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

(3) May cause episodic rather than a continuing period of incapacity<sup>2</sup> (e.g., asthma, diabetes, epilepsy, etc.).

<sup>2</sup> Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

<sup>4</sup> A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

(c). If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

*Prescription drugs*

7 (a). If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind? \_\_\_\_\_

*at present, unable to work*

(b). If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job (the employee or the employer should supply you with information about the essential job functions)? \_\_\_\_\_ If yes, please list the essential functions the employee is unable to perform:

(c). If neither a. nor b. applies, is it necessary for the employee to be absent from work for treatment? \_\_\_\_\_

8 (a). If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation? \_\_\_\_\_

(b). If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? \_\_\_\_\_

(c). If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

*Agnes E. Langner MD PhD*  
(Signature of Health Care Provider)

*Family Practice*  
(Type of Practice)

*2305 Fairmount Ave*  
(Address) *Phila, Pa 19130*

*215-503-8057*  
(Telephone number)

To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for your to work less than a full schedule:

\_\_\_\_\_  
(Employee signature)

\_\_\_\_\_  
(Date)

H-86

# FAMILY AND MEDICAL LEAVE REQUEST CERTIFICATION FORM

1. Employee's Name:

2. Patient's Name (if different from employee):

3. The attached sheet describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category.

(1) ☒ (2) ☒ (3) ☐ (4) ☒ (5) ☐ (6) ☒ or None of the above

4. Describe the medical facts which support your certification, including a brief statement of how the medical facts meet the criteria of one of these categories:

*Alcohol abuse, Hypertension*

5 (a). State the approximate date the condition commenced, and the probable duration of condition (and also the probable duration of the patient's present incapacity if different):

*Alcohol abuse 2/01  
HTN 5/01*

*Depression 2/01*

(b). Will it be necessary for the employee to take work only intermittently or to work on than full schedule as a result of the condition (including for treatment described in Item below)? *yes*

If yes, give the probable duration:

(c). If the condition is a chronic condition (condition #4) or pregnancy, state whether patient is presently incapacitated<sup>2</sup> and the likely duration and frequency of episodes of incapacity:

*Hypertension - needs chronic treatment*

6 (a). If additional treatments will be required for the condition, provide an estimate of probable number of such treatments:

*HTN - indefinite*

If the patient will be absent from work or other daily activities because of treatment intermittent or part-time basis, also provide an estimate of the probable number and between such treatments, actual or estimated dates of treatment if known, and period for recovery if any:

*HTN - not really  
indefinite*

*ETOH abuse  
& Depression*

(b). If any of these treatments will be provided by another provider of health services (physical therapist), please state the nature of the treatments:

<sup>1</sup> Here and elsewhere on this form, the information sought relates only to the condition the employee is taking FMLA leave.

<sup>2</sup> "Incapacity," for purposes of FMLA, is defined to mean inability to work, attend, or perform other regular daily activities due to the serious health condition, treatment, or recovery therefrom.

H-87



Verbal Release of  
records given by  
Patient to Dr.  
Kangner & Lupa  
6/6/01



Worldcom  
TMP

May 26, 2001

Michael McKinnis  
2000 Hamilton St # A569  
Philadelphia, PA 19130

Policy Holder: Worldcom, Inc.  
Claimant: Michael McKinnis  
SSN: 486-78-0916  
Policy Number: GRH 671565

215-266-  
4446

Dear Mr. McKinnis:

In order to fully evaluate this claim for Short Term Disability (STD) benefits, we need the following information:

Based on the information we received, your effective date of coverage under this policy was 08/01/2000. Since your disability began within the first 90 days of your coverage, we must investigate your claim to be sure that your disability has not resulted from a pre-existing condition.

Please have your physician(s) send in all medical records and test results between the look back period of 10/3/00 through 12/31/00 for your present condition. Also, we need Dr. Silver's dictation notes on his evaluation of your first office visit. Your employer needs to send in sick hours paid to you

from 4/20/01 through 5/17/01 or medical information that certifies your disability during this period with complications, restrictions, functional limitations, treatment plan and estimated return to work date. All information is due on or prior to 6/11/01.

Please return all requested information within thirty (30) days in order to avoid any delays in processing your claim for benefits.

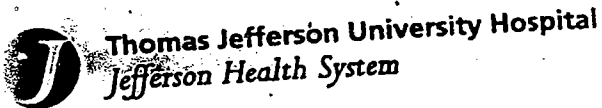
If you have any questions, please feel free to contact our office at (800) 729-1223. Our office hours are 8:00 AM to 6:00 PM EST, Monday through Friday.

Sincerely,

Tim M. Palmer, President  
Hartford Life and Accident Insurance Co.

Health Maintenance Services  
Hartford Life and Accident Insurance Co.  
P.O. Box 1234  
Hartford, CT 06183  
(800) 729-1223

\*\* TOTAL PAGE.02 \*\*



MR#

ENC#

Name

Michael McKinnis

Jefferson Medical Care - Fairmount  
Progress Notes

Complete or Imprint with Address-O-Plate

Plans

Date/Problems  
No. and Description

Findings  
(subjective and Objective)

5/18/01

Wt  
221BP  
152/110

③ 37 yo ♂ here for exam re:  
medial heart - ST disability  
for ETOH abuse.

Med: Ativan D Flexeril 10 mg  
Nasonup (LAP) -

ROS

Head - post op eye h/a. -  
stomach related. Pain 7/10 -  
sleeps - Taken Valium 10 mg  
for sleep No nausea.  
No auras.

Eyes - Popping

Nose - (D) nasal congestion } Eyes

Throat - allergies } Ears

CV: No CP - palpitations  
stress. No edema - 0 rxn.

Resp. a. dyspnea, cough

Asthma previously

GI - episodic stomach burning  
burping: - ↑ to 100

• Nausea • reflux

GU: • dysuria, • ED

↓ ejaculation semen

output over past 4 mos.

Hx: LBP - football on college

MVA 1994 - takes Flexeril

pm. Ankle pain B/L.

Endocrine: "thirsty" all the time -  
• polyuria

MUG 98.5099

IMPORTANT: DO NOT WRITE IN MARGINS

Date/Problems o. and Description	Findings (subjective and Objective)	Plans
	Psych: Bad sleeping - cant stay asleep. Feeding depressed - job very stressful. Appetite ↓ ↓ orientation. ⊕ anhedonia, crying. problems getting up in Am Wants to sleep all the time. ⊕ repetitive thinking Denies suicidality	1 SMAT, UA EC, CFT HUTZ 25mg qd Wishes to refer V med's until he sees therapist must work.
⑩ LA 140/112 RA 150/112 10-14/98 Affect somewhat depressed. Content appropriate. Heard NCAT Neck supple, NT, & massen, & brach RT RML & @ S, S4 Chest LTA Abd soft, NT, & massen Extremities • Full ROM • No deformities • pulses 2+ bll. • No tenderness Strength 5+ bll.	Form for ST disability	
⑪ HTN - newly diagnosed RSD 1 NK Alcohol abuse Depression		
5/31/01	⑫ Disability hasn't kicked in yet - Heart felt needs more med's. Feeling better.	
⑬ 66T ↑ to 155 - other LFTs SLC elevated. BP 160/102		

MUG 98.5099



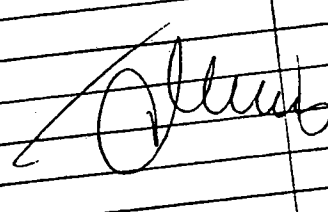

Thomas Jefferson University Hospital  
Jefferson Health System

ENC#  
Name

McKennis, Michael

Complete or Imprint with Address-O-Plate  
Plans

Jefferson Medical Care - Fairmount  
Progress Notes

Date/Problems No. and Description	Findings (subjective and Objective)	Plans
5/31/01	At 11 AM @ check CTA Pulse at No palpable chord	FA 315 474- 1948
		Prinzide 10/12- 10/26
	VE H9V ETOH above	ERG
	S. Frazier - LRP	RID 2 Wks ✓ BP
		
		

IMPORTANT: DO NOT WRITE IN MARGINS



THOMAS JEFFERSON UNIVERSITY HOSPITAL  
CLINICAL and ANATOMIC PATHOLOGY  
DIRECTOR, FRED GORSTEIN, M.D.

SUZANNE LANGNER CRNP (FAIRMOUNT)  
C/O LOUIS PETRONE MD  
2305 FAIRMOUNT AVE  
PHILA PA 19130-2515

PATIENT MCKINNIS, MICHAEL  
PATIENT TELEPHONE No. (215) 999-9999  
AGE 37Y SEX M DOB: 06/19/1963  
MR No. 3138771 ACCT No. 21914538

\*\*\*\*\* SERUM CHEMISTRY \*\*\*\*\*

TEST: GGT  
UNITS: IU/L  
RANGE: 10-40

05/18/01  
1200

155H

*pull chart*

*[Signature]*

\*\*\*\*\* SERUM LIPIDS \*\*\*\*\*

TEST:	Cholesterol	HDL	LDL- (Calc)	Triglyceride
Desirable :	<200 mg/dL	>50mg/dL	<130mg/dL	
Borderline:	200-240mg/dL	40-50mg/dL	130-160mg/dL	
High Risk :	>240 mg/dL	<40mg/dL	>160mg/dL	
UNITS:	mg/dL	mg/dL	mg/dL	mg/dL
RANGE:				60-250

05/18/01  
1200

173

46

102

126

END OF REPORT

FINAL EPISODE REPORT

PAGE 3

PATIENT: MCKINNIS, MICHAEL  
X=NEW DATA THIS REPORT

LOCATION: NONL  
H, L, OR \*=ABNORMAL RESULT PRINTED 05/21/2001 00:17

THOMAS JEFFERSON UNIVERSITY HOSPITAL  
CLINICAL and ANATOMIC PATHOLOGY  
DIRECTOR, FRED GORSTEIN, M.D.



SUZANNE LANGNER CRNP (FAIRMOUNT)  
C/O LOUIS PETRONE MD  
2305 FAIRMOUNT AVE  
PHILA PA 19130-2515

PATIENT MCKINNIS, MICHAEL  
PATIENT TELEPHONE No. (215) 999-9999  
AGE 37Y SEX M DOB: 06/19/1963  
MR No. 3138771 ACCT No. 21914538

\*\*\*\*\* URINALYSIS: MACROSCOPIC \*\*\*\*\*

DATE:	05/18/01	REF RANGE	UNITS
TIME:	1200		
LOC:	NONL		
Color	LIGHT AMBER*		YEL
Appearance	CLEAR		CLER
Spec. Grav.	1.027H	1.010-1.025	
pH	5		5-8
Protein	NEG		NEG
Glucose	NEG		NEG
Ketone	NEG		NEG
Bilirubin	NEG		NEG
Blood	NEG		NEG
Nitrite	NEG		NORM
Urobil.	NORMAL		NEG
Leuk. Est.	NEG		

\*\*\*\*\* URINALYSIS: MICROSCOPIC \*\*\*\*\*

DATE:	05/18/01	REF RANGE	UNITS
TIME:	1200		
LOC:	NONL		
Cells	NONE SEEN		/HPF
Casts	NONE SEEN		/LPF
Crystals	NONE SEEN		/HPF
Other Observ.	1+ BACTERIA		/HPF

*Handwritten signature*

CONTINUED

FINAL EPISODE REPORT

PAGE 1

PATIENT: MCKINNIS, MICHAEL  
X=NEW DATA THIS REPORT

LOCATION: NONL  
H, L, OR \*=ABNORMAL RESULT PRINTED 05/21/2001 00:17





Thomas Jefferson University Hospital  
Jefferson Health System

THOMAS JEFFERSON UNIVERSITY HOSPITAL  
CLINICAL and ANATOMIC PATHOLOGY  
DIRECTOR, FRED GORSTEIN, M.D.

SUZANNE LANGNER CRNP (FAIRMOUNT)  
C/O LOUIS PETRONE MD  
2305 FAIRMOUNT AVE  
PHILA PA 19130-2515

PATIENT MCKINNIS, MICHAEL  
PATIENT TELEPHONE No. (215) 999-9999  
AGE 37Y SEX M DOB: 06/19/1963  
MR No. 3138771 ACCT No. 21914538

\*\*\*\*\* BASIC METABOLIC PANEL/CHEM 7 PANEL \*\*\*\*\*

DATE:	05/18/01	REF RANGE	UNITS
TIME:	1200		
LOC:	NONL		
Sodium	137	135-146	mmol/L
Potassium	4.2	3.5-5.0	mmol/L
Chloride	104	98-109	mmol/L
CO2	23 L	24-32	mmol/L
Anion Gap	10	4-16	mmol/L
Urea-N	9 L	10-22	mg/dL
Glucose	95	60-110	mg/dL
Creatinine	1.1	0.7-1.4	mg/dL
Calcium	9.5	8.5-10.5	mg/dL

\*\*\*\*\* HEPATIC PANEL \*\*\*\*\*

DATE:	05/18/01	REF RANGE	UNITS
TIME:	1200		
LOC:	NONL		
Total Protein	7.5	6.0-8.5	g/dL
Albumin	4.7	3.2-4.9	g/dL
Total Bili	0.3	0.2-1.2	mg/dL
Direct Bili	0.0	0.0-0.4	mg/dL
Alk Phos	61	29-92	IU/L
AST(GOT)	43 H	7-42	IU/L
ALT(GPT)	46 H	1-45	IU/L

CONTINUED

FINAL EPISODE REPORT

PAGE 2

PATIENT: MCKINNIS, MICHAEL  
x=NEW DATA THIS REPORT

LOCATION: NONL  
H, L, OR \*=ABNORMAL RESULT PRINTED 05/21/2001 00:17

05/31/2004  
38 years Male

Oper: MPH

Rx:

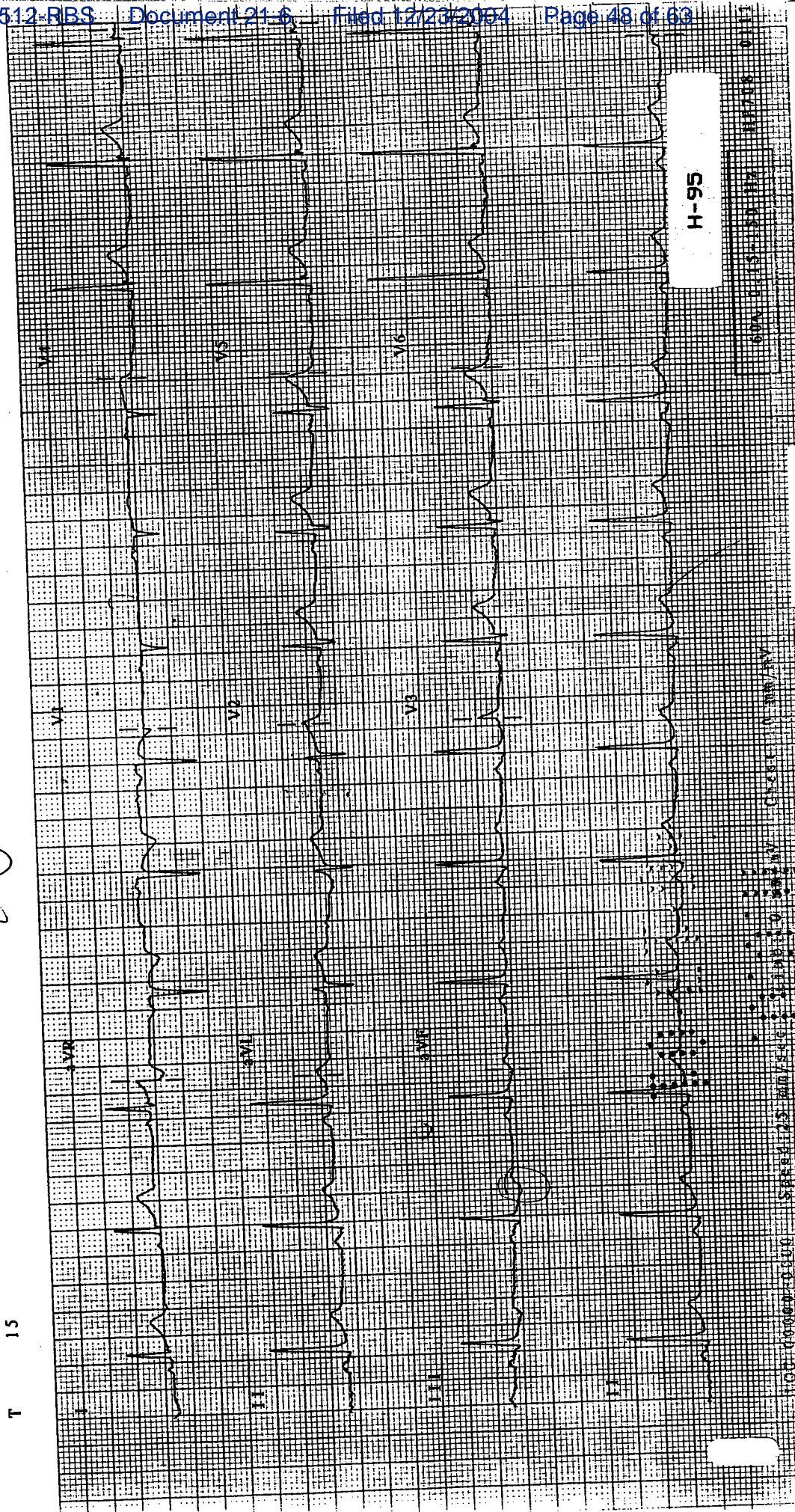
70 Normal sinus rhythm, rate 70... Normal P axis, PR, rate & rhythm  
151 Early transition... QRS positive in V2  
77 Nonspecific inferior T abnormalities... T neg or T/QRS ratio <.05 2,3,F  
339  
366

Requested by:  
LANGNER

--AXIS--  
P 67  
QRS 65  
T 15

BORDERLINE ECG -

PRELIMINARY-MD MUST REVIEW



H-95

60mm 1.5 sec 10mm/mV

REORDER HP M1707A



## FAMILY AND MEDICAL LEAVE REQUEST CERTIFICATION FORM

1. Employee's Name:

2. Patient's Name (if different from employee):

3. The attached sheet describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition <sup>1</sup> qualify under any of the categories described? If so, please check the applicable category.(1) ☒ (2) ☒ (3) ☐ (4) ☒ (5) ☐ (6) ☒ or None of the above ☐

4. Describe the medical facts which support your certification, including a brief statement of how the medical facts meet the criteria of one of these categories:

Alcohol abuse, Hypertension

5 (a). State the approximate date the condition commenced, and the probable duration of condition (and also the probable duration of the patient's present incapacity <sup>1</sup> if different):Alcohol abuse 2/01  
HTN 5/01

Depression 2/01

(b). Will it be necessary for the employee to take work only intermittently or to work on a reduced schedule as a result of the condition (including for treatment described in Item 5(a))?

yes

If yes, give the probable duration:

(c). If the condition is a chronic condition (condition #4) or pregnancy, state whether the patient is presently incapacitated <sup>2</sup> and the likely duration and frequency of episodic incapacity <sup>1</sup>:

Hypertension - needs chronic treatment

6 (a). If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments:

HTN - indefinite

If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number of such treatments, actual or estimated dates of treatment, if known, and the probable duration of recovery if any:

HTN - visit monthly  
indefiniteETOH abuse  
& Depression

(b). If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments:

<sup>1</sup> Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.<sup>2</sup> "Incapacity," for purposes of FMLA, is defined to mean inability to work, attend or perform other regular daily activities due to the serious health condition, treatment of which is necessary for recovery therefrom.

(c). If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

*Prescription drugs*

7 (a). If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind? \_\_\_\_\_

*at present, unable to work*

(b). If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job (the employee or the employer should supply you with information about the essential job functions)? \_\_\_\_\_ If yes, please list the essential functions the employee is unable to perform:

(c). If neither a. nor b. applies, is it necessary for the employee to be absent from work for treatment? \_\_\_\_\_

8 (a). If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation? \_\_\_\_\_

(b). If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? \_\_\_\_\_

(c). If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

*Angela E. Langner CRNP PhD*  
(Signature of Health Care Provider)

*Family Practice*  
(Type of Practice)

*2305 Fairmount Ave*  
(Address) *Phila, Pa 19130*

*215-503-8057*  
(Telephone number)

To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for your to work less than a full schedule:

\_\_\_\_\_  
(Employee signature)

\_\_\_\_\_  
(Date)

A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. Hospital Care

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity<sup>2</sup> or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

(a) A period of incapacity<sup>2</sup> of more than three consecutive calendar days (including any subsequent treatment or period of incapacity<sup>2</sup> relating to the same condition), that also involves:

(1) Treatment<sup>3</sup> two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or

(2) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment<sup>4</sup> under the supervision of the health care provider.

3. Pregnancy

Any period of incapacity due to pregnancy, or for prenatal care.

4. Chronic Conditions Requiring Treatments

A chronic condition which:

(1) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

(2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

(3) May cause episodic rather than a continuing period of incapacity<sup>2</sup> (e.g., asthma, diabetes, epilepsy, etc.).

<sup>2</sup> Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

<sup>4</sup> A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

5. Permanent/Long-term Conditions Requiring Supervision

A period of incapacity<sup>2</sup> which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity<sup>1</sup> of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

Report: E401773R  
 Office: Syracuse Disability Claim Office  
 Date of Report: 05/15/2002

The Hartford - Benefit Management Services  
 Comments: Summary Detail Report  
 Date Range: 04/23/2001 - 05/09/2002  
 For business Role: Examiner  
 Claimant: Michael McKinnis 486-78-0946  
 Case: Worldcom, Inc.  
 Claim Owner: Jennifer E Chajka Role: Examiner Office: Syracuse

Page 1

05/09/2002 04:45:02 p.m. ET Amy L Fraher Examiner Syracuse  
 Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

received summons; sent overnight to law department and made copy for file.

01/22/2002 02:43:36 p.m. ET Tania M Scholder Examiner Syracuse  
 Type of Call: Incoming Date of Call: 01/22/2002  
 Name: Adrian Reid-Attorney  
 Phone: Extension: Fax Number:

Call To/From: Attorney  
 Conversation with: Adrian Reid

Adrian Reid, clmt's attorney called to check status of claim.  
 attempted to call J. Chajka-who took med and recieved vm.  
 Consulted L. Morgan and Adrian was transferred to her vm.

10/19/2001 10:55:56 a.m. ET Kimberly L Colbert Examiner Syracuse  
 Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

rcvd corrected auth from ee to release info to hartford insurance comp

10/16/2001 03:54:55 p.m. ET Baronda C Staten Examiner Syracuse  
 Type: Mail Receipt

auth fax rec'd

10/16/2001 09:23:10 a.m. ET Tina M Palmer Examiner Syracuse  
 Type of Call: Outgoing Date of Call: 10/16/2001  
 Name: Law Offices Of Adrian Reid  
 Phone: (267) 256-0901 Extension: Fax Number:

Call To/From: Attorney  
 Conversation with:  
 Not Contacted: Left Message

CALLED ATTNV - LMSG ON MACHINE ..... AUTHORIZATION IS ADDRESSED TO "TO WHOM IT MAY CONCERN"....  
 \*\*\*\*\*AUTHORIZATION NEEDS TO BE ADDRESSED TO HARTFORD LIFE TO RELEASE INFORM. TO ATTNV \*\*\*\*\*

10/16/2001 09:14:39 a.m. ET Tina M Palmer Examiner Syracuse  
 Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

\*\*\*\*\*rec'd a cover ltr from attny: adrian reid - attached is authorization form signed by ee dated 9/17/01....  
 TO WHOM IT MAY CONCERN:

Report: E401773R  
 Office: Syracuse Disability Claim Office  
 Date of Report: 05/15/2002

Page 2

The Hartford - Benefit Management Services  
 Comments: Summary Detail Report  
 Date Range: 04/23/2001 - 05/09/2002  
 For Business Role: Examiner  
 Claimant: Michael McKinnis 486-78-0946  
 Case: Worldcom, Inc.

Claim Owner: Jennifer E Chajka Role: Examiner Office: Syracuse

THIS WILL AUTHORIZE YOU TO RELEASE TO MY ATTORNEYS, RODGERS AND REID, THEIR AGENT(S) OR REPRESENTATIVE(S) THE ORIGINALS OR TRUE AND CORRECT COPIES OF ANY AND ALL HOSPITAL, MEDICAL, POLICE, EMPLOYMENT AND EARNINGS, BANK OR OTHER RESEARCH RECORDS, INFORMATION, AND/OR OTHER DOCUMENTATION REQUESTED BY THEM IN CONNECTION WITH THE MATTERS WHEREIN THEY REPRESENT ME. MY ABOVE - NAMED ATTORNEYS HAVE BEEN RETAINED BY ME TO PROSECUTE A CLAIM, AND YOUR FULL COOPERATION WITH THEM IS REQUESTED. YOU ARE FURTHER INSTRUCTED TO DISCLOSE NO INFORMATION TO ANY PERSON(S) WITHOUT WRITTEN AUTHORITY FROM US TO DO SO. THIS SHALL CONSTITUTE THEIR SUFFICIENT POWER OF ATTORNEY FOR OBTAINING SUCH INFORMATION, RECORDS, AND/OR DOCUMENTATION.....

"THIS DOES NOT INDICATE THAT HARTFORD LIFE IS AUTHORIZED TO RELEASE INFO. "

10/11/2001 11:31:27 a.m. ET Kimberly L Colbert Examiner Syracuse  
 Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

RCVD AUTH FROM EE TO SPEAK WITH ATTY ADRIAN REID.

10/09/2001 03:44:30 p.m. ET Amy Wrightsman Examiner Syracuse  
 Type: Mail Receipt

fax recv'd. autho to release med

10/05/2001 05:02:10 p.m. ET Tina M Palmer Examiner Syracuse  
 Type of Call: Outgoing Date of Call: 10/05/2001  
 Name: Law Offices Of Adrian Reid  
 Phone: (267) 256-0901 Extension: Fax Number:

Call To/From: Attorney  
 Conversation with:  
 Not Contacted: Left Message

recd ltr from attny/mr. reid - dated 9/25/01 to contact him - or this matter can only be resolved by civil litigation & other administrative remedies addressed to the hartford  
 called attny - lmsg on answering machine - advised need signed autho w/ee & attny's names - having ee authorize hartford to release claim inform. - ee has recd a denial ltr that explains info. needed....

10/02/2001 09:25:22 a.m. ET Amy J Fairbanks Syracuse  
 Type: Mail Receipt

Rec. mail

06/25/2001 10:42:08 a.m. ET Tina M Palmer Examiner Syracuse  
 Type of Call: Outgoing Date of Call: 06/25/2001  
 Name: Law Offices Of Adrian Reid  
 Phone: (267) 256-0901 Extension: Fax Number:

Call To/From: Attorney  
 Conversation with:  
 Not Contacted: Line Busy

speke to april - lmsg advised need signed autho. from ee to release info. & recd ltr w/out attached ltr as noted

H-101



Report: E401773R  
 Office: Syracuse Disability Claim Office  
 Date Of Report: 05/15/2002

The Hartford - Benefit Management Services  
 Comments: Summary Detail Report  
 Date Range: 04/23/2001 - 05/09/2002  
 For business Role: Examiner  
 Claimant: Michael McKinnis 486-78-0946  
 Case: Worldcom, Inc.

Claim Owner: Jennifer E Chajka Role: Examiner Office: Syracuse

06/25/2001 10:36:25 a.m. ET Tina M Palmer Examiner Syracuse  
 Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

recd a ltr fax dated 6/20/01 - from law offices of adrian r. reid 2207 chestnut street sute 200 philadelphia, pa 19103 phone number 267 256 0901 - please be advised that I have been retained in the above. enclosed please find a June 15, 2001 report from dr. petrone, it is self - explanatory. in particular, my client is making a claim for short term disability starting on 5/18/01. the plain language of the policy as well as your correspondence indicates that he is entitled to same. if you have any questions or concerns please do not hesitate to contact me. please be advised that for the purposes of your organization this is a "appeal", as I understand that term to be used by the hartford. ....  
 there is no attachment to this fax ltr - filed

06/21/2001 11:12:04 a.m. ET Baronda C Staten Examiner Syracuse  
 Type: Mail Receipt

letter from att rec'd

06/17/2001 12:30:38 p.m. ET Tina M Palmer Examiner Syracuse  
 Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

recd duplc medical info. - already recd - filed

06/15/2001 12:23:50 p.m. ET Tina M Palmer Examiner Syracuse  
 Type of Call: Outgoing  
 Name: Michael McKinnis  
 Phone: (215) 266-4646

Extension:  
 Fax Number:

Call To/From: Claimant  
 Conversation with:

recd vmgs from ee to call will get atny - called ee - did not rec denial ltr - sent another copy to ee by fax to 215 235 5328  
 advised if ee gets atny to have him call...refaxed copy of denial ltr to ee

06/15/2001 11:42:04 a.m. ET Rheta West Examiner Syracuse  
 Type of Call: Incoming  
 Name: Michael McKinnis  
 Phone: (215) 266-4646

Extension:

Fax Number:

Call To/From: Claimant  
 Conversation with:

advised 5 bus days

H-102

Report: E401773R The Hartford - Benefit Management Services  
 Office: Syracuse Disability Claim Office Comments: Summary Detail Report  
 Date Of Report: 05/15/2002 Date Range: 04/23/2001 - 05/09/2002  
 For business Role: Examiner  
 Claimant: Michael McKinnis 486-78-0946  
 Case: Worldcom, Inc.

Claim Owner: Jennifer E Chajka Role: Examiner Office: Syracuse

06/14/2001 03:17:17 P.M. ET Regina R Irby Examiner Syracuse  
 Type of Call: Incoming Date of Call: 06/14/2001  
 Name: Michael McKinnis  
 Phone: (215) 266-4646 Extension: Fax Number:

Call To/From: Claimant  
 Conversation with:

spoke with ee would like call back with status if approved also / more medical needed.

06/13/2001 10:58:07 a.m. ET Julie A Lamay Examiner Syracuse  
 Type: Mail Receipt

medical records rec'd.

06/13/2001 10:37:39 a.m. ET Tina M Palmer Examiner Syracuse  
 Type of Call: Incoming Date of Call: 06/13/2001  
 Name: Worldcom, Inc. Extension: Fax Number:

Call To/From: Employer  
 Conversation with:

reviewed fnla form - er will need to get further info. there copy has date of 5/14/01 w/ee's signature...faxed from  
 ee's home  
 our copy does not have a date or signature on it & was faxed from the jeff med care per print on fax

06/12/2001 05:53:33 P.M. ET Tina M Palmer Examiner Syracuse  
 Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

A: reviewed medical below - still need to certify db from 4/20 to 5/18/01 - reviewed fnla - fax date 6/6/01 completed by  
 Suzanne la? family practice can not read writing - (lrnp/phd)...fnla reads: 4.d: alcohol abuse, htn 5. (a) date  
 condition commenced & dura. of pt's incapacity: alcohol abuse: 2/01, htn: 5/01, depr: 2/01 (b) will it be necessary to  
 take work, only intermittently or to work on then full schedule as a result of condition? yes if yes give the  
 probable duration: blank (c) if the condition is a chronic condition, state whether pt is presently incapacitated and  
 the likely duration & freq. of episodes of incapacity: htn - needs chronic tx, 6.(a) if additional txs will be required  
 for the condition, provide an estimate probable number of such txs: htn - indefinite. if the pt will be absent from  
 work or other daily activities because of tx interm. or p/t basis, also provide an estimate of probable number and btw  
 such txs actual or estimated dates of tx known & recovery: htn - vist mthly - indefinite, etch abuse & depress (b) any  
 other pt tx: blank (c) regimen: prescription drugs, 7(a). medical leave - unable to work: at present, unable to work  
 (no dates given) (b) if able to perform some work: blank, (c) blank 8. a-c: blank...fnla does not indicate cover for  
 the above period for current dx primary tx for htn by pcip...only give 2 periods of time 2/01(alcohol & depress) &  
 5/01(htn) ..medical notes already recd prior see soap below  
 P: claim remains cls

06/12/2001 08:08:47 a.m. ET Amy L Fraher Examiner Syracuse

H-103



Report: E401773R  
 Office: Syracuse Disability Claim Office  
 Date Of Report: 05/15/2002

Page 5

The Hartford - Benefit Management Services  
 Comments: Summary Detail Report  
 Date Range: 04/23/2001 - 05/09/2002  
 For Business Role: Examiner  
 Claimant: Michael McKinnis 486-78-0946  
 Case: Worldcom, Inc.  
 Claim Owner: Jennifer E Chajka Role: Examiner Office: Syracuse

Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

faxed dr for tx plan for etoh abuse and depression, requested gaf score, frequency of therapy for depression-poss rtw  
 date-f/u 6/25/01, email to examiner for decision

06/12/2001 08:01:23 a.m. ET Amy L Fraher Examiner Syracuse  
 Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

rec'd copy of fmla papers-also rec'd ov notes from 5/18/01 and 5/30/01, per notes, ee still using alcoholol; etoh abuse,  
 htn, trouble sleeping, lbp which started in college, depression-takes flexeril, naprosyn, allegra, valium-nov 7/10/01-bp  
 readings:  
 140/112, 150/114, 140/98 on 5/30/01, 160/100 on 5/31/01, 152/110 on 5/18/01-appears that depression and etoh abuse are  
 primary diagnosis-tx plan, for depression and etoh abuse not given

06/11/2001 01:59:46 p.m. ET Tina M Palmer Examiner Syracuse  
 Type of Call: Incoming  
 Name: Worldcom, Inc.  
 Phone: Extension: Fax Number:

Call To/From: Employer  
 Conversation with:

has 3way w/ee/er & I as to the info. needed

06/08/2001 11:06:22 a.m. ET Tina M Palmer Examiner Syracuse  
 Type of Call: Outgoing  
 Name: Worldcom, Inc.  
 Phone: Extension: Fax Number:

Call To/From: Employer  
 Conversation with:

reviewed claim - ee has not sent in fmla - er sent reminder - fmla due by 6/18/01 ...ee can not get vacation paid till  
 appeal  
 process is done

06/07/2001 02:51:36 p.m. ET Tina M Palmer Examiner Syracuse  
 Type of Call: Outgoing  
 Name: Michael McKinnis  
 Phone: (215) 266-4646 Extension: Fax Number:

Call To/From: Claimant  
 Conversation with:  
 Not Contacted: Left Message

called ee - lmsg - advised of status

06/07/2001 02:50:35 p.m. ET Tina M Palmer Examiner Syracuse  
 Type of Call: Outgoing  
 Date of Call: 06/07/2001

Call To/From: Employer

H-104

Report: E401773R  
Office: Syracuse Disability Claim Office  
Date Of Report: 05/15/2002

The Hartford - Benefit Management Services  
Comments: Summary Detail Report  
Date Range: 04/23/2001 - 05/09/2002  
For business Role: Examiner  
Claimant: Michael McKinnis 486-78-0946  
Case: Worldcom, Inc.

Page 6

Claim Owner: Jennifer E Chajka Role: Examiner Office: Syracuse

Name: Worldcom, Inc.  
Phone:

Extension: Fax Number:

Conversation with:  
Not Contacted: Left Message

recd email from dorrine to call - called left msg advised of status

06/07/2001 10:35:26 a.m. ET Baronda C Staten Examiner Syracuse  
Type: Mail Receipt

med fax rec'd

06/07/2001 08:59:07 a.m. ET Tina M Palmer Examiner Syracuse  
Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

A: recd email from hr/dorrine - has not recd any fmla paper work back from the employee - resent email back still need info.  
if ee used vac. or sick time from 4/20 to 5/18/01....correction did rec email ee used sick time thru 4/27/01 - no vacation there...under the plan language on pg 10 & 11, termination define - not txd by a physician & exclusion - not an active employee - ee does not provide fmla for period of 4/20/01 thru 5/17/01....  
P: denied - mailed ltr to ee & er

06/06/2001 02:59:57 p.m. ET Tina M Palmer Examiner Syracuse  
Type of Call: Outgoing Date of Call: 06/06/2001  
Name: Ent  
Phone: (215) 955-6000 Extension: 6760 Fax Number:

Call To/From: Physician  
Conversation with:

A: spoke to rachel - fov: 5/2/01 dx: allergies ? no referral from another pl.  
there appears to be that prex would not apply - do not have any pi tvg during the look back period  
med would only support from 5/18 to 5/31/01 .....CAN NOT APPROVE STILL NEED VERIFICATION  
OF COVERED TIME FROM LDM: 4/20/01 THRU 5/17/01 per ee took vac. - no medical certifying period  
prior to 5/18/01 - will need further medical update from the psychiatrist that pcg referred ee to  
P: emailed dorrine blea to verify time used

06/06/2001 02:55:30 p.m. ET Tina M Palmer Examiner Syracuse  
Type of Call: Outgoing Date of Call: 06/06/2001  
Name: Pcp  
Phone: Extension: Fax Number:

Call To/From: Physician  
Conversation with:

spoke to joy - fov: 5/18/01 ...prior ee was seen by dr. pribitkin -215- 955 - 6000

H-105

Report: E401773R The Hartford - Benefit Management Services  
 Office: Syracuse Disability Claim Office Comments: Summary Detail Report  
 Date Of Report: 05/15/2002 Date Range: 04/23/2001 - 05/09/2002  
 For business Role: Examiner  
 Claimant: Michael McKinnis 486-78-0946  
 Case: Worldcom, Inc.

Claim Owner: Jennifer E Chajka Role: Examiner Office: Syracuse

06/06/2001 02:52:11 p.m. ET Tina M Palmer Examiner Syracuse  
 Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

A: recd med from 6/1 & 6/4/01  
 William Silver/dsw - dx: 296.23 & 305.00 ee experiencing depr & anxiety - to the point ee felt that there were many personal factors contributing to his anxiety including substance abuse, financial concerns, aging and work related pressures, notes these symptoms have continued for the past 6mths - ee drinks 1 - 2 bottles @ wk uses cocaine - but notes stopped at this time, many areas of ee's life are in chaos, relationship problems as well as career problems, ee would ultimately like to change careers for a less stressful job - recommendation: ee would do well in an alcohol reh. prog. OP tx, ee is impulsive, structure of prog. would give opportunity to focus on some life goals - motivated.....

dr. petrone/pcp notes 5/18 & 5/31/01 has had sleeping - can't stay asleep, feeling depress, job bry stressfull, depr. appetite, depr. concentration, + anhedronia ?? not sure of writing, crying or raging ?, problems getting up, + repet. thinking, denies suicide, b/p: 150/114 & 140/98, 160/ 101 A: htn - newly diagnosed, alcohol abuse, depression ggt incr. to 155 past hx: football in college, mva 1994, ankle pain, thirsty all the time ....in k6 ee was referred to a psychiatrist by pcp  
 recd no info. from psychiatrist.....pcp was ee oow as of 5/18/01 for OP program .....recd no medical records for look back period for pre-x or any er info. verify vac time doh: 1/24/00  
 P: will call pcp to verify any tx in look back period & email er on any vac time ee taken prior to 5/18/01 to 4/20/01

06/06/2001 10:41:35 a.m. ET Geraldine C Ashley Examiner Syracuse  
 Type of Call: Incoming Date of Call: 06/06/2001  
 Name: Michael McKinnis  
 Phone: (215) 266-4646 Extension: Fax Number:

Call To/From: Claimant  
 Conversation with:

status? advised we would try to rush.

06/04/2001 05:55:18 p.m. ET Albert R Kunsman Examiner Syracuse  
 Type of Call: Incoming Date of Call: 06/04/2001  
 Name: Worldcom, Inc.  
 Phone: Extension: Fax Number:

Call To/From: Employer  
 Conversation with:

status of review.

06/04/2001 04:18:18 p.m. ET Loreena M Lobdell Examiner Syracuse  
 Type of Call: Incoming Date of Call: 06/04/2001  
 Name: Michael McKinnis  
 Phone: (215) 266-4646 Extension: Fax Number:

Call To/From: Claimant  
 Conversation with:

clmt cld for status...i advised clmt of 5-7 days...clmt wanted to talk to exm, TMP was busy, xferr'd to VM

Report: E401773R

The Hartford - Benefit Management Services

Page 8

Office: Syracuse Disability Claim Office  
Date Of Report: 05/15/2002

Comments: Summary Detail Report  
Date Range: 04/23/2001 - 05/09/2002

For business Role: Examiner  
Claimant: Michael McKinnis 486-78-0946

Case: Worldcom, Inc.

Claim Owner: Jennifer E Chajka Role: Examiner Office: Syracuse

06/04/2001 10:02:36 a.m. ET Phyllis B Sattler Examiner Syracuse

Type of Call: Incoming  
Name: Michael McKinnis

Date of Call: 06/04/2001

Phone: (215) 266-4646

Extension:

Fax Number:

Call To/From: Claimant  
Conversation with:

EE re: status? wants c/b from exam, today for info as to review

06/04/2001 09:21:35 a.m. ET Amy Wrightsman Examiner Syracuse

Type: Mail Receipt

fax recv' ov note

06/01/2001 03:01:31 p.m. ET Baronda C Staten Examiner Syracuse

Type: Mail Receipt

med fax rec'd

05/31/2001 05:27:01 p.m. ET Tina M Palmer Examiner Syracuse

Type of Call: Outgoing  
Name: Michael McKinnis  
Phone: (215) 266-4646

Date of Call: 05/31/2001

Extension:

Fax Number:

Call To/From: Claimant  
Conversation with:

rtc to ee - advised still need all medical for look back period - per ee will have dr. silver info. tomorrow & faxed -  
per ee  
ee was not tx during that time - noted need in writing from pi

05/31/2001 10:14:57 a.m. ET Albert R Kunsman Examiner Syracuse

Type of Call: Incoming  
Name: Jefferson Medical Ctr.

Date of Call: 05/31/2001

Phone:

Extension:

Fax Number:

Call To/From: Medical Provider  
Conversation with:

nov 5/31/01. liver enzymes high. ggt 155. bp also high. will fax over on today.

05/29/2001 11:26:49 a.m. ET Bonnie L Whitney Examiner Syracuse

Type of Call: Incoming  
Name: Worldcom, Inc.

Date of Call: 05/29/2001

Phone:

Extension:

Fax Number:

Call To/From: Employer  
Conversation with:

ee cld re; claim he would like a copy of letter sent to him faxed so that he can take to pi office now. will fax for ee

Report: E401773R  
 Office: Syracuse Disability Claim Office  
 Date Of Report: 05/15/2002

Page 9

The Hartford - Benefit Management Services  
 Comments: Summary Detail Report  
 Date Range: 04/23/2001 - 05/09/2002  
 For business Role: Examiner  
 Claimant: Michael McKinnis 486-78-0946  
 Case: Worldcom, Inc.  
 Claim Owner: Jennifer E Chajka Role: Examiner Office: Syracuse

at this time.

05/26/2001 09:29:28 a.m. ET Tina M Palmer Examiner Syracuse  
 Type of Call: Outgoing  
 Name: Michael McKinnis  
 Phone: (215) 266-4646  
 Extension: Fax Number:

Call To/From: Claimant  
 Conversation with:

called ee - advised of status of info. need & will send ee prex ltr - will also need dr. silver's notes on his  
 1st eval. of ee - per ee has sick time paid to ee from 4/20 to 5/17/01 - noted to have er verify

05/26/2001 09:28:40 a.m. ET Tina M Palmer Examiner Syracuse  
 Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

A: pre-x look back period 5/3/00 thru 7/31/00 dob: 1/24/00 insur: 8/1/00 thru 7/31/01  
 no med certiff. from 4/20/01 thru 5/17/01 - ee took self oow = 27 days oow  
 pop/dr. petrone db: 5/18/01 dr. silver/psych/therapist - indicated on 5/2/01 did not take ee oow  
 will need to advise ee of no pl certiff. db btw: 4/20 to 5/17/01 & will need call medical records for above  
 look back period  
 P: will call ee & send pre-x ltr & add note

05/25/2001 11:45:39 a.m. ET Tina M Palmer Examiner Syracuse  
 Type of Call: Outgoing  
 Name: Michael McKinnis  
 Phone: (215) 266-4646  
 Extension: Fax Number:

Call To/From: Claimant  
 Conversation with:

recd vmsg from ee - called ee - can not go into inpt. till ee is paid - has to pay rent - so not to loss apt prior to  
 getting  
 out - will be in for 3wks - dr. bill silvers/psychiatrist 215 790 0654 lov: 2wks - seen 2x

05/23/2001 10:02:34 a.m. ET Rheta West Examiner Syracuse  
 Type of Call: Incoming  
 Name: Michael McKinnis  
 Phone: (215) 266-4646  
 Extension: Fax Number:

Call To/From: Claimant  
 Conversation with:

would like a call once rvw'd

05/21/2001 08:40:35 a.m. ET Bonnie L Whitney Examiner Syracuse  
 Type of Call: Incoming  
 Name: Worldcom, Inc.  
 Phone: Extension: Fax Number:

Call To/From: Employer  
 Conversation with:

Report: E401773R The Hartford - Benefit Management Services  
 Office: Syracuse Disability Claim Office Comments: Summary Detail Report  
 Date of Report: 05/15/2002 Date Range: 04/23/2001 - 05/09/2002  
 For business Role: Examiner  
 Claimant: Michael McKinnis 486-78-0946  
 Case: Worldcom, Inc.

Page 10

Claim Owner: Jennifer E Chajka Role: Examiner Office: Syracuse

stat

05/18/2001 05:06:19 p.m. ET Jennifer E Chajka Examiner Syracuse  
 Statement: Physician Type Of Intake: Phone

PI INTAKE> DX DEPRESSION AND ALCOHOL ABUSE, HYPERTENSION.....TX PLAN: EE IS BEING ADMITTED TO INPATIENT TX  
 CENTER.....RX: HYDROCHLORTHIAZIDE 25 MG....PI 1ST TREATED WITH PI TODAY, EE WAS REFERRED TO PI FROM PSYCHIATRIST.

05/18/2001 01:25:50 p.m. ET Albert R Kunsman Examiner Syracuse  
 Type of Call: Incoming Date of Call: 05/18/2001  
 Name: Michael McKinnis  
 Phone: (215) 266-4646 Extension: Fax Number:

Call To/From: Claimant  
 Conversation with:

did pi call?

05/17/2001 12:40:26 p.m. ET Stacey L Juston Examiner Syracuse  
 Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

15day: lack of dbing ap, deny clm, sent letter.

05/16/2001 12:40:11 p.m. ET Lisa Dausman Examiner Syracuse  
 Type of Call: Incoming Date of Call: 05/16/2001  
 Name: Michael McKinnis  
 Phone: (215) 266-4646 Extension: Fax Number:

Call To/From: Claimant  
 Conversation with:

ee called to check status, adv of prev comments, ee got upset & req supervisor, ee hung up

05/05/2001 07:08:05 a.m. ET Maria M Garm Examiner Syracuse  
 Statement: Employer Type Of Intake: Phone

er cert received  
 db1 4/23

05/02/2001 02:54:25 p.m. ET Diane A Sutton Examiner Syracuse  
 Type of Call: Outgoing Date of Call: 05/02/2001  
 Name: Michael McKinnis  
 Phone: (215) 266-4646 Extension: Fax Number:

Call To/From: Claimant  
 Conversation with:

5-day call - c/c to ee, adv'd ee need PI intake. ee to hv pcp call.

Report: EA01773R The Hartford - Benefit Management Services  
Office: Syracuse Disability Claim Office Comments: Summary Detail Report  
Date Of Report: 05/15/2002 Date Range: 04/23/2001 - 05/09/2002  
For business Role: Examiner  
Claimant: Michael McKinis 486-78-0946  
Case: Worldcom, Inc.

Page 11

Claim Owner: Jennifer E Chajka Role: Examiner Office: Syracuse

05/02/2001 11:46:25 a.m. ET Peter A Wrightsman Examiner Syracuse  
Type of Call: Incoming Date of Call: 05/02/2001  
Name: Dr Silver  
Phone: Extension: Fax Number: (215) 573-2099

Call To/From: Physician  
Conversation With:

Tcf Dr Silver psychotherapist. HE ADV HE HAS NOT TAKEN EE OOW. HE HAS ONLY SEEN EE ONCE AND HAS NOT DETERMINED THAT  
YET. I ADV EE NEEDS TO HAVE AP CALL WHO TOLD EE TO STAY OOW. Dr Silver rgsid aps be faxed to him to provide med update  
when needed. 215-573-2099 will fax regular aps and mental health aps.

04/23/2001 12:26:22 p.m. ET Nona I Malfa Examiner Syracuse  
Statement: Employee Type Of Intake: Phone

per call from ee; 1dw; 4/20 (ee very unclear on info)  
dx; work related stress...ee states "checking self in" to a rehab ctr.  
unsure how long will be inpatient.  
dbl; approx 6-8wks.

advised ee to file w.c.; ee states HE is taking self out of work...ee then said it's NOT work related it's personal and  
it's  
affecting his job...ee NOT filing w.c.

H-110